SAN FRANCISCO

VOICE & SWALLOWING

KATHERINE C. YUNG, MD FACS

HEALTH HISTORY FORM

Chosen Name:___________________________ Legal Name/Name on ID (if different): _____________________________

DOB: ______________ Pronoun (Please Circle): He/Him She/Her They/Them Decline Other:____________

Gender (Please Circle):

Male Gender Queer Agender Decline to answer

Female Non-binary Additional Category: _____________________________

What sex were you assigned at birth? (Please Circle)

Male Female Decline to answer

Who referred you to our office? ____________________________ Primary Care Physician: __________________________

What is the **Main Reason** for your visit today? ____

How long has this problem existed?____

ALLERGIES/SENSITIVITIES TO MEDICATIONS: (Please describe reaction) □ *NONE*

CURRENT MEDICATIONS WITH DOSAGE: (Please include over the counter and herbal supplements) □ *NONE*

Pharmacy Preference: ____

PAST MEDICAL HISTORY: ***Circle All That Apply*** □ *NONE*

Anxiety
Asthma
Bleeding disorder
Cancer: _______________
Chronic bronchitis
Depression
GERD (Reflux)
Hearing loss
Heart attack
Heart disease
High Blood Pressure
HIV/AIDS
Lung disease/Pneumonia
Psychiatric Disorder
Sleep Apnea
Stomach ulcers
Stroke
Thyroid disease

OTHER MEDICAL PROBLEMS: ____

PAST SURGICAL HISTORY: ***Circle All That Apply*** □ *NONE*

Bronchoscopy
Cardiac surgery
Esophagus surgery
Facial cosmetic surgery
Lung Surgery
Nasal Surgery
Neck Surgery
Orthopedic Surgery
Throat Surgery
Thyroid Surgery

OTHER SURGICAL HISTORY: ____

FAMILY HISTORY (Blood Relatives): *(P1=Mother; P2=Father; S1=Sister; S2=Brother; C1= Child 1, C2 = Child 2)*
Please check (if applicable): □ Unknown □ Patient is adopted

	P1	P2	S1	S2	C1	C2
Allergies						
Anesthesia problems						
Autoimmune disease						
Asthma						
Cancer (type:)						
Diabetes (type:)						

	P1	P2	S1	S2	C1	C2
Genetic disease						
Heart disease						
High blood pressure						
Psychiatric illness						
Bleeding Disorder						
Other: ___________						

SOCIAL HISTORY*:*
Cigarette use: □ Current Smoker □ Former Smoker (Quit Date:______) □ Never Smoked

If current or former smoker: # cigarettes/day_____________ for ____________ years.

Smokeless: □ Snuff □ Chew □ Other □ Current Smoker □ Former Smoker (Quit Date:______) □ Never Smoked

Alcohol (drinks/week): ________________ Yes No Not Currently

Recreational drugs? Yes No Not Currently

Occupation: ________________________

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REVIEW OF SYSTEMS: *Indicate/circle symptoms you are currently experiencing*

- □ Activity change
- □ Appetite change
- □ Fatigue
- □ Unexpected weight change
- □ Eye Pain
- □ Visual disturbance
- □ Cough
- □ Shortness of Breath
- □ Chest pain
- □ Leg swelling
- □ Abdominal distention
- □ Abdominal pain
- □ Nausea
- □ Vomiting
- □ Heat intolerance
- □ Cold intolerance
- □ Painful urination
- □ Change in urinary frequency
- □ Change in urinary urgency
- □ Joint swelling
- □ Rash
- □ Environmental allergies
- □ Food allergies
- □ Headache/migraine
- □ Numbness
- □ Tremors
- □ Weakness
- □ Bleed easily/Bruise easily
- □ Confusion

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Vocal Fatigue Index (VFI)

These are some symptoms usually associated with voice problems. Circle the response that indicates how frequently you experience the same symptoms (0–never, 1–almost never, 2–sometimes, 3–almost always, and 4–always).

1. I don't feel like talking after a period of voice use	0	1	2	3	4
2. My voice feels tired when I talk more	0	1	2	3	4
3. I experience increased sense of effort with talking	0	1	2	3	4
4. My voice gets hoarse with voice use	0	1	2	3	4
5. It feels like work to use my voice	0	1	2	3	4
6. I tend to generally limit my talking after a period of voice use	0	1	2	3	4
7. I avoid social situations when I know I have to talk more	0	1	2	3	4
8. I feel I cannot talk to my family after a work day	0	1	2	3	4
9. It is effortful to produce my voice after a period of voice use	0	1	2	3	4
10. I find it difficult to project my voice with voice use	0	1	2	3	4
11. My voice feels weak after a period of voice use	0	1	2	3	4
12. I experience pain in the neck at the end of the day with voice use	0	1	2	3	4
13. I experience throat pain at the end of the day with voice use	0	1	2	3	4
14. My voice feels sore when I talk more	0	1	2	3	4
15. My throat aches with voice use	0	1	2	3	4
16. I experience discomfort in my neck with voice use	0	1	2	3	4
17. My voice feels better after I have rested	0	1	2	3	4
18. The effort to produce my voice decreases after I have rested	0	1	2	3	4
19. The hoarseness of my voice gets better with rest	0	1	2	3	4

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VOICE HANDICAP INDEX – 10 (VHI-10)

Below are statements describing your voice and the impact it has on your life. Circle the response that indicates how frequently you have a similar experience.

0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

Statement						
1. My voice makes it difficult for people to hear me.		0	1	2	3	4
2. People have difficulty understanding me in a noisy room		0	1	2	3	4
3. My voice difficulties restrict my personal and social life.		0	1	2	3	4
4. I feel left out of conversations because of my voice		0	1	2	3	4
5. My voice problem causes me to lose income		0	1	2	3	4
6. I feel that I have to strain to speak.		0	1	2	3	4
7. The clarity of my voice is unpredictable.		0	1	2	3	4
8. My voice problem upsets me.		0	1	2	3	4
9. My voice makes me feel handicapped		0	1	2	3	4
10. People ask, "What's wrong with your voice?"		0	1	2	3	4

Please add up your total = ________________

REFLUX SYMPTOM INDEX (RSI)

Within the last month, how did the following problems affect you? Circle the appropriate response.
0 = no problem, 5 = severe problem

Problem							
1. Hoarseness or a problem with your voice		0	1	2	3	4	5
2. Clearing your throat		0	1	2	3	4	5
3. Excess throat mucus or post nasal drip		0	1	2	3	4	5
4. Difficulty swallowing food, liquids, or pills		0	1	2	3	4	5
5. Coughing after you eat or after lying down		0	1	2	3	4	5
6. Breathing difficulties or choking episodes		0	1	2	3	4	5
7. Troublesome or annoying cough		0	1	2	3	4	5
8. Sensation of something sticking in your throat or a lump in your throat		0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up		0	1	2	3	4	5

Please add up your total =___________________

FORM COMPLETED BY (print): ____

SIGNATURE: ____________________________________ **DATE:** ______________

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